CORE TASKS OF PSYCHOTHERAPY WITH VICTIMS OF CUMULATIVE VIOLENCE

Donald Meichenbaum, Ph.D.
Research Director of The Melissa Institute for Violence Prevention
Miami

www.melissainstitute.org
www.roadmaptoresilience.com

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CORE TASKS OF PSYCHOTHERAPY

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Role of Case Conceptualization Model (CCM) that informs assessment and treatment decision-making (*See CCM below and the accompanying report format*).

1. **Assessment Procedures.**

    a. Risk factors toward self and others.

    b. Presence of co-occurring disorders.

    c. Strengths—evidence of resilience, "islands of competence" and access to social resources and supports.

2. **Development, maintenance and monitoring of Therapeutic Alliance—be culturally, developmentally and gender sensitive.**

    a. Use of Motivational Interviewing practices (***See www.motivationalinterviewing.org*).**

    b. Use guided discovery probes—Socratic questioning procedures (***See Art of Questioning below*).**

    c. Use Feedback Informed Treatment (FIT) procedures. FIT asks patients to rate on a session-by-session basis, their progress and the quality of the therapeutic alliance. Bertolino (2017), explains the FIT assessment procedure as follows: (See Bertolino, 2017 use of session-by-session patient ratings).

        "Completing this scale is a bit like taking your temperature. In a minute or less, we can get an idea about how you think things are with you and your life. Just as your temperature tells us something about how much distress your body is in, so do the scores on this scale. And like your temperature, this scale will let us know how things have been with you during the past week up through today, - not tomorrow or in a month. Right now we are trying to understand how we can help you which is more difficult if we don't have a good idea of how you are doing to begin with. Can you help us out?" (Bertolino, 2017, p. 197).

        FIT has patients fill out Outcome Rating Scale (ORS) and Session Rating Scale (SRS) of the therapeutic alliances. The therapist reviews these scores with the patient "where he/she is at," and develops a collaboration strengths-based patient-driven treatment plan (see FIT-Outcomes.com).

3. **Collaborative goal-setting — Nurture hope**

    a. Establish SMART goals (Specific, Measureable, Attainable, Relevant, Timely).

    b. Use goal-attainment scaling procedures — "As yet"; "So far" statements.

    c. Focus on issues of transfer and maintenance of treatment gains across settings and over time in order to achieve "lasting changes."

4. **Conduct Psycho-Education**

    a. Use CLOCK metaphor

        i. **12 o'clock** — External and internal triggers.

        ii. **3 o'clock** — primary and secondary emotions

            - Treat emotions as a "commodity" — "What do you do with your feelings?"

        iii. **6 o'clock** — Automatic thoughts and images.

            - Implicit assumptions.
            - "If … then" rules.
            - Beliefs, developmental schemas.

        iv. **9 o'clock** — Behaviors and reactions of others.

            - Use metaphor of "vicious cycle" and what is the impact, toll, price you and others pay?

    b. Highlight the Role of Resilience — Build and broaden positive emotions and activities.

    c. Use Timelines.

        Timeline 1 — From birth to the present, enumerate stressors (experiences of trauma and exposure to violence), and interventions, if any.

        Timeline 2 — "In spite of behaviors". Evidence of strengths, signs of resilience from birth to the present. Also, include evidence of intergenerational transmission of "strengths". What got passed on? Lessons learned.

        Highlight "exceptions" — when problems not present or less. Be solution-focused.

Timeline 3 — present and future – oriented focused. Start now and extend Timeline into the future.

5. **Teach Intra- and Interpersonal skills**

    a. Focus on emotion-regulation skills and problem-solving skills.

    b. Focus on interpersonal skills — "scripted" behaviors.

    c. Build in generalization guidelines (Do before, during and after training — put the patient in a Consultative Role). Use patient checklist.

6. **Conduct Relapse Prevention Procedures and self-attributable training procedures ("Taking credit" statements). Use meta-cognitive and RE verbs — "notice, catch, plan", etc. and RE-new, RE-connect, RE-author.**

7. **Provide Integrative Treatment approaches, where indicated to address the presence of co-occurring disorders, such as complex PTSD, depression, substance abuse disorders. (See Alexander et al. 2013; Jaycox, 2004, 2009, Wolmer et al. 2011).**

8. **Provide Active Aftercare and Follow-through Procedures. Conduct a:**

    a. Risk analysis-triggers. Use CLOCK metaphor.

    b. Use booster sessions.

    c. Use ongoing internet consultations.

    d. Involve significant others in treatment, throughout (***See list of websites for family-based interventions***).

ART OF QUESTIONING: USE OF "WHAT" AND "HOW" QUESTIONS

"***Let me explain what I do for a living. I work with folks like yourself and try to find out how things are right now in your life and how you would like them to be"***

"I want to find out what you have tried in the past to bring about these changes, achieve your goals? What worked, what has not work, as evident by_____? What help did you receive, if any? What did you have difficulty following through with?"

"If <u>we</u> worked together, and I hope <u>we</u> can, how would <u>we</u> know if you were making progress? What would other people notice change in your life?

"Permit me to ask one last question, if I may. Can you foresee, envision anything that might get in the way of your achieving your goals, changing, improving the situation? Can you think of a plan of action, where you can anticipate such possible obstacles or barriers to change? What do you think can be done?"

OTHER QUESTIONS
(*Bertolino, 2017*)

"How have you been doing personally?"

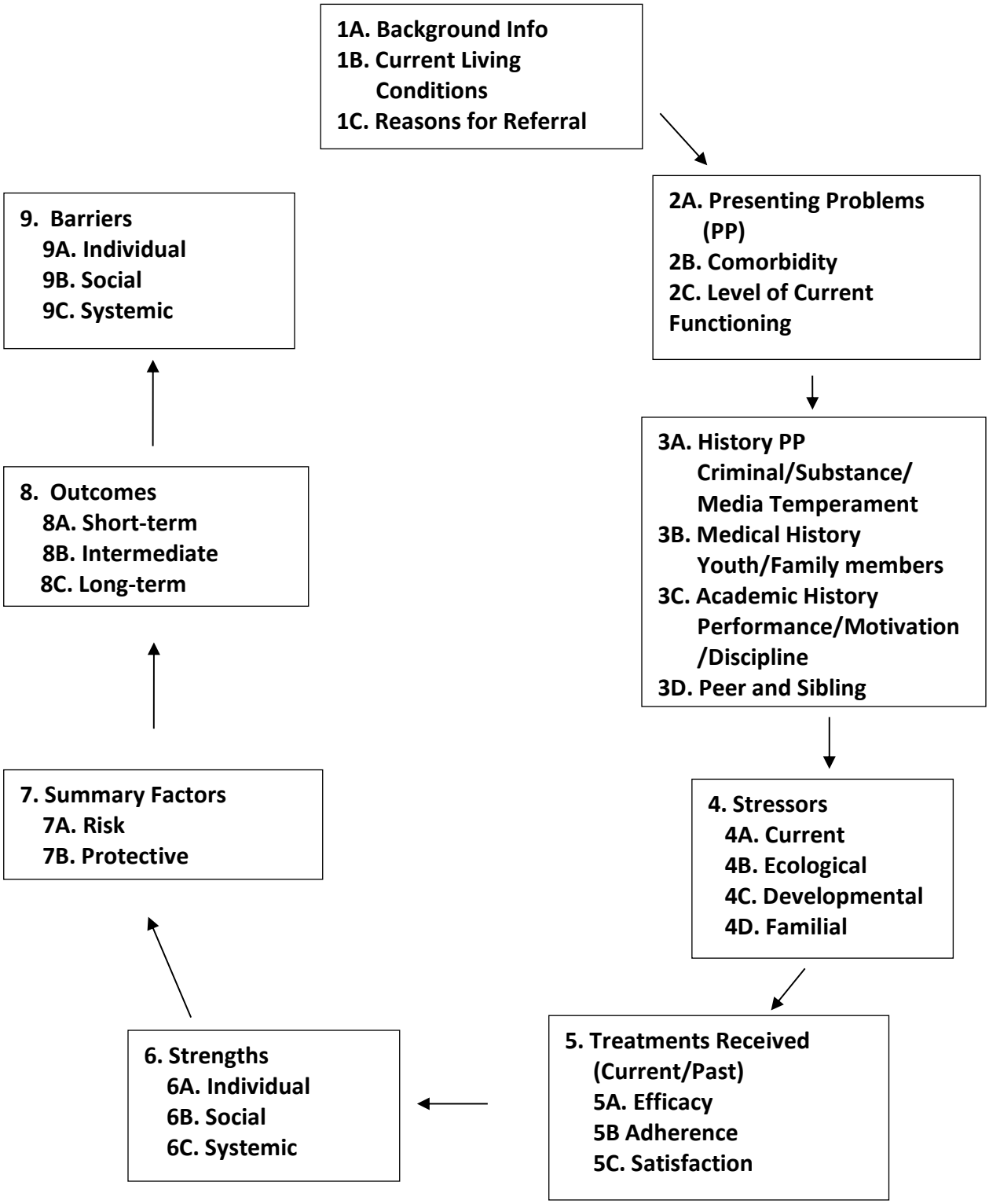
"How have things been going in your relationship? How are you getting along with your parents, friends, boss?"

"How are things going for you socially?"

"How has your life been outside of your home (in your community, school, church, work)?"

"Overall, how are things going in your life?"

GENERIC CASE CONCEPTUALIZATION MODEL



COMPUTER-GENERATED REPORT BASED ON CASE CONCEPTUALIZATION MODEL (CCM)

(The numbers and letters in the report refer to information in the Boxes in the CCM)

Introduction

This (age, gender, race) (**1A** – information) who currently lives (indicate geographic area) with (**1B –** information). The housing situation (note any specific concerns about threats to safety – "**red flags**"). The date and reason for referral by …. (**1C)**.

Presenting Problems

The **presenting problems** include… (**2A)** (Note the source of information and if violence is indicated, the role of weapons, injuries, substance abuse and peers – violence was an isolated act or part of a peer group).

In addition, the youth also experiencing difficulties with … (**2B –** comorbidity). These presenting and comorbid problems are having an impact on the level of functioning as evident by…

An examination of the youth's **developmental history** reveals … (review prior record and history of presenting problems and history of comorbid problems – **3A**). These behavioral problems were accompanied by … (exacerbated by…) – medical history (**3B**) and academic history (**3C**) and by peers and sibling influences such as (**3D**).

An examination of **current and past stressors** for both the youth and his family members reveals … (**4A to 4D**). **[Note: In particular, the source of information for developmental stressors such as victimization (4C) and familial stressors (4D).]**

For these various presenting and comorbid problems and stressors, the youth and his/her family are currently receiving (or have received) the following treatments … (cite specific interventions, by whom, when) with what effects … **(5A**) (cite source of information). Some of the difficulties encountered with this treatment included … (Cite source of information for **treatment nonadherence – 5B**). Based on their treatment experiences the youth and his/her parents or caregivers were particularly satisfied with (dissatisfied with) … because … (**5C**).

In spite of the difficulties and the presence of … (list "risk" factors, stressors) the youth and his parents were able to achieve … (cite source for **individual and familial strengths – 6A** and **6B**). The "strengths" that the youth and his family have going for them are … They can also access (note, **community** and **agency** resources – **6C**).

In **summary**, an examination of the "risk" factors and adversities indicate (**7A**), but a consideration of protective factors (**7B**) also reveals (Note: "challenges" and "opportunities").

In terms of the **Goal Attainment Scale (GAS)**, the major three target behaviors to be addressed initially include … The agreed-upon signs of improvement negotiated with the youth and his/her family are … (**For each target behavior note what the specific change would look like**.)

	Specific Ways Behavior Should Change			
	Minimal Improvement	**Moderate Improvement**		**Significant Improvement**
0% Change	**25% Change**	**50% Change**	**75% Change**	**100% Change**

Target Behavior 1

Target Behavior 2

Target Behavior 3

In collaboration with the youth and his/her family, the following assessments and treatment goals and plans have been established, as noted on the **Goal Attainment Scaling (GAS)** procedure. The short-term (**8A**), intermediate (**8B**), and long-term (**8C**) goals that will be worked on are … More specifically, the individualized treatment plan for the youth and his family indicates that a follow-up assessment should include … ***(What additional information is needed and how and when is it to be obtained); placement (amount of supervision required – least to most restrictive in light of likelihood of further offences); treatment options (what should be done, by whom, when and how will generalization/transfer and evaluation be built into the treatment plan).***

In order for these changes to occur, the following **barriers** at the individual (**9A**), familial-social (**9B**) and systemic levels (**9C**) have to be addressed. (***Note, how these barriers were identified.***) The intervention plans to address these barriers include … The evidence that they have been addressed successfully include data that … (***Note data like that included on GAS – 0% to 100% change***).

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EXAMPLE OF WEBSITES FOR FAMILY-BASED INTERVENTIONS

Treatment Manual for Coping with Depression Course

www.kpchr.org/acwd.html

Interpersonal Therapy for Adolescents

www.interpersonaltherapy.org

Parent-Child Interaction Therapy

www.pcit.org

Yale Parenting Center and Child Conduct Clinic

www.yale.edu/childconductclinic
www.oup.com/ptm
www.alankazdin.com

Multidimensional Treatment Foster Care

www.hackney-gov.uk/fostering-MFTC.html

Multisystemic Therapy

www.mstservices.com

Triple-P—Positive Parenting

www.triplep.net

ACT Raising Safe Kids

www.apa.org/act/

Incredible Years Parenting Program

www.incredibleyears.com

Trauma-Focused Cognitive Behavior Therapy

www.musc.edu/tfcbt

Brief Strategic Family Therapy for Adolescent Drug Abuse

www.drugabuse.gov/pdf/Manual5.pdf

Practice Wise – Evidence-based Youth Mental Health Services Literature Database

www.practice-wise.com

Hawaii Department of Health: Child and Adolescent Mental Health Division Annual Evaluation Report

www.hawaii.gov/health/mental-health.camhd/index.html

National Academy of Parenting Practices

www.parentingacademy.org
www.commissioningtoolkit.org